TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Medical Group

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-17-0244-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially the claim was submitted on 01/12/2016. We never received a Denial or Approval for the above claims. On 05/13/2016 we issued an appeal and finally received a denial stating it was being denied due to timely filing [sic] Till this day we have yet to receive any payments on the above DOS."

Amount in Dispute: $355.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel hereby certifies a complete medical bill for the date(s) of service 12/01/15 and 12/10/15 were not received within the 95-day statutory and regulatory deadline."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2015 December 10, 2015	90837 90837	$355.72	$355.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the billing requirements for medical claim submission.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time limit for filing claim/bill has expired

Issues

1. Is the respondent's position supported?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule that applies to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $355.72 for reimbursement of professional services rendered on December 1 - 10, 2015.

   The carrier states in their position statement, "Please note CorVel is the proprietary clearing house for fulfilling medical bill processing obligations for Federal Insurance Company."

   Review of the Carrier Information via https://txcomp.tdi.state.tx.us, "TexComp," finds the Group Affiliation for Federal Insurance Co as, "Chubb Group of Insurance Co."

   Insufficient evidence was found to support the position that the services in dispute should have been submitted to CorVel as stated by the respondent.

   Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines discussed below.

2. The insurance carrier denied disputed services with claim adjustment code 29 – "Time limit for filing claim/bill has expired." 28 Texas Administrative Code §133.20 (b) states in pertinent part:

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Review of the submitted information finds;

   - Document titled, "Accepted Claim Detail" dated January 18, 2016, line 8, DOS 12/01/2015, ChubbServices (J1561), for claimant.
   - Document titled, "Accepted Claim Detail" dated January 19, 2016, line 8, DOS 12/10/2015, ChubbServices (J1561), for claimant.

   28 Texas Administrative Code §102.4(h) states in pertinent part:

   > Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   >
   > (1) the date received, if sent by fax, personal delivery or electronic transmission

   The carrier's denial is not supported as the date of electronic transmission of the claims in question was within the 95 day timely filing requirement.

   The services in dispute will be reviewed per the applicable fee guidelines below.

3. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Date of Service	Submitted Code	Units	Billed Amount	Allowable	MAR / DWC Conversion Factor/Medicare Conversion Factor x Allowable = MAR
December 1, 2015	90837	1	$177.86	$129.91	56.2/35.9335 x $129.91 = $203.18

December 10, 2015	90837	1	$177.86	$129.91	56.2/35.9335 x $129.91 = $203.18
				Total	$406.36

The maximum allowable reimbursement is $406.36. The requestor is seeking $355.72. This amount is recommended.

4. Based on the information submitted and the applicable rules and fee guidelines the Division finds the requestor is due the amount requested of $355.72.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $355.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $355.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.